

STATE OF MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

121 - _____STATE FILE NUMBER

(TYPE OR PRINT IN INK)

REPORT OF FETAL DEATH

CHILD	1. CHILD'S NAME (FIRST) (If parent's choose to		RST)	(MIDDLE)				(LA			AST) (SUF		FIX)	2. SEX OF CHILD	_
CHILD	provide a name)			VEIGE	VEIGHT 5. OBST		ETRIC ESTIMATE O		F 6. DATE OF DELIVE		RY	7. TIME OF DELIVERY	_		
	3. NAME AND TITLE OF ATTENDANT			(Specify unit)					ON (completed weeks)		(Month, Day, Year)		M		
PLACE OF DELIVERY	8a. FACILITY NAME (If not institution, give street, number, at			nd zip code) 8b. CIT			Y, VILLAG	VILLAGE, OR TOWNSHIP OF D			PELIVERY 8c. COUNTY OF			F DELIVERY	
PARENT(S)	9. MOTHER'S CURF	RENT LEGAL NAME (First, Middle, Las	t)	I_		10. F	ATHER'S	S CURREN	T LEGAL	. NAME (First	Middle Last)			_
'	—		CONFIDEN	ITIAL INEOD!	MATION	EOB	A DMINIS	CTD ATI	VE AND I	III IC	UEALTUI	ISE ONLY			_
	11. MOTHER'S FULL	NAME BEFORE FIRS		NTIAL INFORMATION FOR ADMINISTRA IF 12. MEDIC					RECORD			13. EXPECT		E OF PAYMENT FOR	-
	DIFFERENT FRO					MOTHER MEDICAL SERVICES (Private Insurance, Medicaid, etc.)									
MOTHER	14a. RESIDENCE OF MOTHER - STATE			14b. COUNTY OF RESIDENCE			CE	14c. RESIDENCE - PLACE (Check one box and specify) INSIDE CITY OR VILLAGE OF INSIDE TOWNSHIP OF UNINCORPORATED PLACE OF							
	15. RESIDENCE STREET ADDRESS			16. ZIP CODE 17. N			MOTHER'S MAILING ADDRESS IF DIFFERENT FROM RESIDENCE (Street Number, City or Village, State, Zij)
PARENT(S)	OCUMENOTURA DIP			H (Mo, Day, Yr) DELI			MOTHER MARRIED AT VERY <u>OR</u> CONCEPTION? or No)				19a. FATHER'S STATE OF BIRTH - NAME COUNTRY IF NOT USA			19b. FATHER'S DATE OF BIRTH (Mo, Day, Yr)	_
1	etc. (If Asian give nationality, i.e. Chinese, En			CESTRY - Mexican, Cuban, Arab, ylish, French, Dutch, etc. If American			n OF		SPANIC RIGIN		20d. EDUCATION - Indicate the category that best describes the highest degree or level of school completed by the Mother and the Father				_
MOTHER	Filipino, etc.)(Ente	er all that apply)	Indiar	an, enter principal tribe. (Enter all th			nat apply) (Ye		es or No)		1 8th grade or less 7 Master's degree (MA, MS, MEng, 2 9th - 12th grade; no diploma MEd, MSW, MBA)				
MOTHER	>					3	3 High school graduate or GED 8 Doctorate or Professional degree (PhD 4 Some college but no degree EdD, MD, DO, DDS, DVM, LLB, JD)								
FATHER									Associate de Bachelor's de	wn					
	FOR HERSELF DURING THIS PREGNANCY?			22. DATE LAST NORMAL MENS (Mo, Day, Year)			23a. DATE OF FIR CARE VISIT				23b. DATE OF LAST PR CARE VISIT (Mo.,			23c. TOTAL PRENATAL CARE VISITS	
	Yes No 24a. PLURALITY OF THIS PREGNANCY Single, Twin, Triplet, etc.(Specify)		24b. IF NOT S			25a. MOTHER SMO OR DURING P (Yes or No)				HOW	bb. IF MOTHER QUIT SMOKING, HOW LONG AGO? (weeks, months, years)		25c. DO OTHERS IN HOUSEHOLD SMOKE? (Yes or No.	-	
'	26. PREGNANCY HISTORY (Comple			each section)					OR MATERNAL MEDICAL OR FET				ŀΥ		
MEDICAL AND	LIVE BI	IRTHS		PREGNANCY	INDICATIONS FOR DELIVER If yes enter name of facility transf				sferred from: 2[MD 2 DO			
HEALTH ORMATION	26a. NOW LIVING	26b. NOW DEAD		neous and induc oic pregnancies)	20 PLAC	9. PLACE WHERE DELIVERY O						NURSE CERTIFIED NURSE MIDWIFE			
	Number Number			er 1 HOSPITA				OSPITAL		6	6 CLINIC/DOCTORS OFFICE 7 OTHER (Specify) 5 6			CERTIFIED MIDWIFE	
	None None None None			3 НОМЕ			OME - PL		rer 7	S OTHER MIDWIFE OTHER					
	26c. DATE OF LAST LIVE BIRTH 26e. DATE										HER'S PREPREGNANCY 31b. MOTHE		HER'S WEIGHT AT DELIVER	Ϋ́	
	(Mo., Day, Year) OUTC			OME (Mo., Day, Year)			(feet/ir	(feet/inches)		WEIG	GHT (pounds)		ds)		
	32. RISK FACTORS IN THIS PREGNANCY (Check all that apply or check none):			34. METHOD OF DELIVERY							IAL MORBIDITY (Complications di with labor and delivery) (Check			ENITAL ANOMALIES OF FETUS (Check all that apply or	•
	Diabetes 1 Prepregnancy (Diagnosis prior to this pregnancy) 2 Gestational (Diagnosis in this pregnancy)			A. Was delivery with forceps attempted but unsu 1 Yes 2 No				ccessful?			ply or check none)		l	check none) Anencephalus	
	Hypertension 3 Prepregnancy (Chronic) 4 Gestational (PH, preeclampsia, eclampsia)			B. Was delivery with vacuum extraction unsuccessful?				n attempted but 1			transfusion			Meningomyelocele/Spina Bifida Congenital heart disease Cyanotic congenital heart disease Congenital diaphragmatic hernia Omphalocele	
				1 Yes 2 No C.Fetal presentation at delivery?				2 Third or fr							
	5 Previous preterm birth 6 Other previous poor pregnancy outcome (includes perinatal death, small-growth restricted birth) 7 Vaginal bleeding during this pregnancy prior to the			1 Cephalic							7			halocele roschisis reduction defect (excluding	
	onset of labor 8 Pregnancy resulted from infertility treatment 9 Mother had a previous cesarean delivery			2 Bree 3 Oth	y (check one) 3			red uterus	ned hysterectomy 9 10			congenital amputation and dwarfing syndromes)			
	10Alcohol use during pregnancy			D. Final route and				nned hyste				9 Cleft Lip with or without Cleft Palate 10 Cleft Palate alone 11 Down Syndrome			
	0 ☐ None of the above 33. INFECTIONS PRESENT AND/OR TREATED			1 Vaginal/Spontaneous Vaginal/Forceps			S		5 Admi:	ssion to inte	on to intensive care unit			Karyotype confimed Karyotype pending	
	DURING THIS PREGNANCY (Check all that appl			3 Vaginal/Vacuum 4 Cesarean					Unplanned operating room procedure following delivery			14 Suspected chromosomal disorder 15 Karyotype confirmed			
	1 Gonorrhea 8 Parvo virus 2 Syphilis 9 Toxoplasmosis 3 Genital Herpes			If cesarean, was a trial of labor			r attempted?						16	Karyotype pending ospadias	
	3 Genital Herpes 4 Chlamydia 10 Other (Specify) 5 Listeria Group B Streptococcus 7 Cytomegalovirus 0 None of the above			E. Hysterotomy/Hysterectomy				0 None of th			the above			er (specify)	-
Į	Cytomegalovirus 0 None of the above			1 Yes 2 No										00 None of the anomalies listed above	
ſ	CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH														
	37a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE SELECT THE			37b. OTHER S			USES OR			38.	38. ESTIMATED TIME OF FETAL DEATH				
	ONE WHICH MOST LIKE EVENTS RESULTING IN CHECK UNKNOWN)		JTING TO I		IN ITEM 37							no labor ongoing labor ongoing			
	Maternal Conditions/Dise	Maternal Condit	ions/Disea	ses (Sp	pecify)			_	_	ring labor, aftern In time of feta		ssment			
CAUSE OF							- '								
FETAL DEATH	Complications of Placent 1 Rupture of members.	Complications of Placenta, Cord, or Membranes 1 Rupture of membranes prior to onset of labor					39a.		JTOPSY PER						
	2 Abruptio placenta 3 Placental insuffic	2 Abruptio placenta 3 Placental insufficiency						1 Yes 2 No 3 Planned							
	4			4 Prolapsed cord 5 Chorioamnionitis 6 Other (Specify)					39b.	39b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION					
	Other Obstetrical or Preg	Other Obstetrical or Pregnancy Complications (Specify)					-	PERFORMED?							
	Fetal Anomaly (Specify)			Fetal Anomaly (Specify)					- 39c.	1 Yes 2 No 3 Planned 39c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL					
	Fetal Injury (Specify)			Fetal Injury (Specify)					_	EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?					
	Fetal Infection (Specify)								-	1 Yes 2 No					
				Fetal Infection (Specify)					-	40a. NAME OF PERSON COMPLETING REPORT (TYPE OR PRINT)					
	Other Fetal Conditions/Disorders (Specify)			Other Fetal Conditions/Disorders (Specify)					40b.	. DATE REF	ORT COMPL	ETED (Mont	th, Day, Year)	_	
Į	9 🔲 Unknown			9 Unknown											